



Resource based view: a promising new theory for healthcare organizations

Comment on “Resource based view of the firm as a theoretical lens on the organisational consequences of quality improvement”

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Abstract

This commentary reviews a recent piece by Burton and Rycroft-Malone on the use of Resource Based View (RBV) in healthcare organizations. It first outlines the core content of their piece. It then discusses their attempts to extend RBV to the analysis of large scale quality improvement efforts in healthcare. Some critique is elaborated. The broader question of why RBV seems to be migrating into healthcare management research is considered. They conclude RBV is a promising new theory for healthcare organizations.

Keywords: Resource Based View (RBV), Strategy, Knowledge Mobilization, Healthcare Organizations

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Knowledge mobilisation has recently become a theme of major interest in UK health policy and other health systems internationally, stimulating academic work by health management researchers (1,2) to access knowledge orientated theoretical perspectives. This knowledge perspective is relatively new in this domain, perhaps surprisingly so, given that healthcare organizations have long been knowledge intensive settings, including a scientific and technological base which can rapidly evolve. The effective mobilization of new scientific and clinical knowledge influences these organizations' ability to create (public) value for patients and society.

A knowledge based perspective has been framed in various ways. One well-known perspective addresses the 'bench to bedside' cycle and how to increase the pace of diffusion of evidence-based innovations in healthcare. The extensive Evidence-Based Medicine (EBM) literature has concentrated on problems of evidence-based behaviour change in the clinical group. However, a wider question emerges: how can – or indeed can – complex healthcare organizations mobilise organizational and management knowledges to stimulate innovation, productivity and performance?

This macro perspective opens the door to different theoretical perspectives at the organizational level. These theories may be novel for the health management field, including models of strategic management originally developed for private sector firms. Their application within publicly funded settings (such as the UK NHS) may be problematic or require customization, but nevertheless they provide interesting insights. There has recently been increased interest in the Resource Based View (RBV) of the firm from the strategic management literature to provide new ideas (2) for healthcare organizations.

Burton and Rycroft-Malone's short overview paper accesses RBV theory to analyse the impact of (often complex) quality improvement efforts in healthcare (3). Their paper firstly reviews basic RBV theory [notably Valuable, Rare, Imperfectly Imitable, Non-Substitutable (VRIN), dynamic capabilities and absorptive capacity] so these definitions will not be repeated here. These concepts help them understand the locally variable impact of complex quality improvement programmes. As the underlying organizational capabilities to support effective implementation of quality efforts (e.g. the organizational ability to learn, to change and collaborate across boundaries) are variably distributed, important and complex to decode, RBV offers a useful framing. This view restates the idea in the organizational studies literature (4) that the organizational context shapes local receptivity to change. RBV theory assumes that underlying organizational resources come in bundles, may be tacit in nature and difficult to surface through formal analysis, so that competitors find it difficult to imitate a successful brand (or healthcare planners to replicate good practice).

They highlight perceived limitations of RBV theory: that publicly funded settings (e.g. UK NHS) are more complex than the private firms where RBV originated and that much quality improvement efforts take place in interorganizational networks rather than a large, vertically integrated, organization. They argue that RBV's use in healthcare management research has been limited empirically [but see Casebeer *et al.* (5) on dynamic capabilities in the Albertan healthcare field; Harvey *et al.* (6) on poor absorptive capacity in failing UK public service organizations, including healthcare sites] but that it is a promising theoretical prism. Burton and Rycroft-Malone (3) are firstly to be commended

for their explicitly theorised approach and for bringing in RBV. Their article remains unusual in this respect, raising wider issues about the often problematic status of the Health Services Research (HSR) and health management research fields, which tend to be functionalist, captured by a policy agenda, atheoretical and insulated from wider social science. In the UK (with its tax financed health system), HSR has proved allergic to theories such as RBV with its roots in (actually rather heterodox in Business School terms) private sector models of strategy.

What puzzle does RBV help them address? RBV concepts help them understand the (locally variable) outcomes of major quality improvement efforts. There are here problems of understanding high organizational complexity which cannot be reduced to simple cause effect relations or one variable. There are other theoretical prisms, such as complexity theory, systems thinking or work around organizational receptivity (4) available to analyse highly complex settings, but RBV is a good start.

Empirical findings may be negative as well as positive: Harvey *et al.* (6) found that failing UK public services – including healthcare – organizations display poor absorptive capacity, ignoring ready evidence of deteriorating performance until a crisis unfolds. One example is the Board in Mid Staffs NHS Foundation Trust (FT) (7), which repeatedly missed warning signs that the quality of clinical care was collapsing in the organization it supposedly governed.

How can Burton and Rycroft-Malone's article inform future work? Clearly, the high level RBV concepts (VRIN, dynamic capabilities and absorptive capacity) introduced need operationalization and customization within healthcare settings. We need to be clearer about which VRIN resources are important and how they operate (specifying Context Mechanism Outcome configurations, in the parlance of realist evaluation).

Their suggestion that private sector models of strategy such as RBV require adaptation to not for profit settings in healthcare seems intuitively sound. But is this view now dated? A counter argument is that new organizational forms (such as NHS FTs) may still be largely not for profit (although even this is now changing as private income grows) but they are also competitive between each other. Moreover, they face explicit performance management and measurement (8) regimes. Their corporate performance matters reputationally and contractually and furthermore appears variably distributed. RBV theory may enable such sites to understand determinants of their local performance and supply tools to improve it. Their second argument that organizational competences are expressed within diffuse inter organizational networks (such as healthcare managed networks) as well as in traditional large vertically integrated and stand alone organizations is important: is the ability to work, learn and change across organizational boundaries now a core competence?

A broader question arises: how do new theories diffuse into the health management domain from outside? Three factors seem to have facilitated diffusion in the case of

RBV. The first is a sustained growth of policy level interest in – and funding for – Knowledge Management and quality improvement programmes so there are empirical phenomena to study. Secondly, and associated with this policy interest, commissioned health management research, including literature syntheses (1,2) as well as primary research, has introduced these concepts to the health management academic community. This example confirms the creative role that literature reviews can play as a bridge to emergent fields. Thirdly, Burton and Rycroft-Malone's critical realist approach (helpfully) requires an explicit programme theory which considers contexts and mechanisms which mediate programme impact. Their method, in other words, requires them to search for a coherent theory.

All in all, therefore, their paper usefully opens the door to RBV theory in healthcare organizations and raises wider questions about how the inter sectoral transfer of management theories into healthcare management research takes place.

Ethical issues

Not applicable.

Competing interests

Author declares that he has no competing interests.

Author's contribution

EF is the single author of the manuscript.

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